

Exhibit D to Complaint

U.S. ex rel. Roark, et al. v. Medical University of South Carolina, et. al.

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FORM CMS-2552-10

4030.1

4030. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under the **IPPS** and title XVIII (Part B) settlement for medical and other health services. Worksheet E-3 computes title XVIII, Part A settlement for non-IPPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a PPS. Worksheet E-4 computes total direct GME costs.

Worksheet E consists of the following two parts:

Part A - Inpatient Hospital Services Under the IPPS

Part B - Medical and Other Health Services

Application of Lesser of Reasonable Cost or Customary Charges--Worksheet E, Part B, allows for the computation of the lesser of reasonable costs or customary charges (LCC), where applicable, for services covered under Part B. Make a separate computation on each of these worksheets. In addition, make separate computations to determine whether the services on any or all of these worksheets are exempt from LCC. For example, the provider may meet the nominal charge criteria for the services on Worksheet E, Part B, and, therefore, be exempt from LCC only for these services.

For those provider Part B services exempt from LCC for this reason, reimbursement for the affected services is based on 80 percent of reasonable cost net of the Part B deductible amounts.

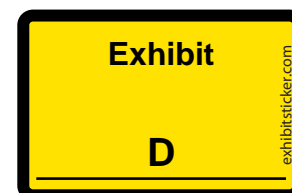
4030.1 Part A - Inpatient Hospital Services Under the IPPS--

For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102 and 103), subscript column 1 for lines 1 through 3, 22, 28, 29, 33, 34, 41, 45, 47, and 48. For SCH/MDH status changes see additional instructions at line 35.03. If you responded "1" and "2", or "2" and "1", to Worksheet S-2, Part I, questions 26 and 27, respectively, which indicated your facility experienced a change in geographic classification status during the year, subscript column 1, and report the payments before the reclassification, and on or after the reclassification in the applicable column. *Effective for cost reporting periods ending on or after June 30, 2018, if a SCH experienced a change in geographic reclassification (Worksheet S-2, Part I, questions 26 and 27, answered "1" and "2", or "2" and "1", respectively) and the hospital maintained the SCH status for the entire cost reporting period, do not subscript column 1; report all payments, both before and after the geographic reclassification, in column 1.*

For cost reporting periods that overlap or begin on or after October 1, 2014, if you responded "Y", to Worksheet S-2, Part I, line 22.03, column 1 or 2, which indicated your facility experienced a change in geographic redesignation as a result of the OMB standards for delineating statistical areas adopted by CMS in FY 2015, subscript column 1, for lines 33 and 34.

For SCH or MDH status change, enter on lines 1 through 3, in column 1, the applicable payment data for the period applicable to SCH or MDH status. Enter on lines 1 through 3, in column 1.01, the payment data for the period in which the provider did not retain SCH or MDH status. The data for lines 1 through 3 must be obtained from the provider's records or the PS&R.

For IPPS hospitals participating in Model 4 of the Bundled Payments for Care Improvement (BPCI) initiative, IME and disproportionate share hospital (DSH) payments will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model, as will outlier payments and hospital capital payments (see **CR** 8196, dated February 15, 2013). Enter on lines 1.03 and 2.02, in column 1, the applicable payment data for the cost reporting period.



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Line Descriptions

Line 1--The amount entered on this line is the sum of the federal specific operating portion (DRG payments) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. For cost reporting periods overlapping October 1, 2013, and subsequent years, do not complete line 1, but complete lines 1.01 and 1.02.

Line 1.01--For cost reporting periods that overlap October 1, 2013, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring prior to October 1. For example, a calendar year provider would include DRG payments for discharges occurring during the period of January 1 through September 30.

Line 1.02--For cost reporting periods that begin or overlap October 1, 2013, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring on or after October 1. For example, a calendar year provider would include DRG payments for discharges occurring during the period of October 1 through December 31.

Line 1.03--Enter the amount of the federal specific operating portion (DRG payments) for Model 4 bundled payments for care improvement (BPCI) initiative, effective for discharges occurring on or after October 1, 2013. Effective for cost reporting periods that overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1.

Line 1.04--Effective for cost reporting periods that begin or overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring on or after October 1.

Line 2--Enter the amount of outlier payments made for PPS discharges during the *cost reporting period*. See 42 CFR 412, Subpart F, for a discussion of these items. *For cost reporting periods that begin on or after October 1, 2018, do not complete line 2, but complete lines 2.03 and 2.04.*

Line 2.01--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line 92.

Line 2.02--Effective for discharges occurring on or after October 1, 2013, enter the amount of outlier payments made for Model 4 BPCI discharges during the cost reporting period.

Line 2.03--For cost reporting periods that begin on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring prior to October 1 of the cost reporting period. For example, a calendar year provider would include outlier payments for discharges occurring during the period of January 1, through September 30.

Line 2.04--For cost reporting periods that begin on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring on or after October 1 of the cost reporting period. For example, a calendar year provider would include outlier payments for discharges occurring during the period of October 1, through December 31.

Line 3--Hospitals receive payments for IME for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture in conjunction with the PPS PRICER the simulated payments. Enter the total managed care "simulated payments" from the PS&R.

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Line 4--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 3, line 14) by the number of days in the cost reporting period (365, or 366 in case of leap year). Effective for cost reporting periods beginning on or after October 1, 2012, enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 3, line 14, plus line 32) by the number of days in the cost reporting period (365, or 366 in case of leap year).

NOTE: Reduce the bed days available by swing-bed days (Worksheet S-3, Part I, column 8, sum of lines 5 and 6), and the number of observation days (Worksheet S-3, Part I, column 8, line 28). In addition, effective for cost reporting periods beginning on or after October 1, 2011, reduce the bed days available by the number of non-distinct part hospice days (Worksheet S-3, Part I, column 8, line 24.10) and effective for cost reporting periods beginning on or after October 1, 2012, the number of outpatient ancillary labor and delivery days (Worksheet S-3, Part I, column 8, line 32.01).

Indirect Medical Educational Adjustment Calculation for Hospitals--Calculate the IME adjustment only if you answered "yes" to line 56 on Worksheet S-2, and complete lines 5 through 29.01, as applicable. In addition, a hospital may be entitled to the IME adjustment if Worksheet S-2, line 56, is "no" and lines 13 and/or 14 are greater than zero. (See 42 CFR 412.105.) Hospitals that incur indirect costs for GME programs are eligible for an additional payment as defined in 42 CFR 412.105(d). This section calculates the additional payment by applying the applicable multiplier of the adjustment factor for such hospitals.

Calculation of the IME adjusted FTE Resident cap in accordance with 42 CFR 412.105(f):

Line 5--Enter the FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996, (*see* 42 CFR 412.105(f)(1)(iv)). Adjust this count for the 30 percent increase for qualified rural hospitals and also adjust for any increases due to primary care residents that were on approved leaves of absence (*see* 42 CFR 412.105(f)(1)(iv) and (xi) respectively). Temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 412.105(f)(1)(ix) are applicable. (Effective October 1, 2001, see 42 CFR 413.79(h)(3)(ii)).

Line 6--Enter the FTE count for allopathic and osteopathic programs that meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e).

For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For urban hospitals that participate in training residents in a new program for the first time on or after October 1, 2012, under 413.79(e)(1), the cap is effective beginning with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals that participate in training residents in a new program on or after October 1, 2012, under 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, the rural hospital's FTE resident cap is adjusted for each new program effective with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of each new program started (see 79 FR 50110 (August 22, 2014)).

For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997, is reported on this line and is effective in the fourth program year of each of those new programs (see 66 FR 39881 (August 1, 2001)). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 5. Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap adjustment on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap

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adjustment are reported on line 16. For urban hospitals that already have an FTE cap adjustment on line 5 but start a rural track program in accordance with 42 CFR 413.79(k), enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.79(l) and the hospital qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), do not report FTE residents in the rural track program on this line during the time frame prior to the effective date of the hospital's FTE cap).

Line 7--Enter the section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1).

Line 7.01--Enter the section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If this cost report straddles July 1, 2011, calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period.) Otherwise enter the full cap reduction amount.

Line 8--Enter the adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).

Line 8.01--Enter, as applicable, all of or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of the ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011, through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, for portions of cost reporting periods occurring during the 5-year evaluation period (July 1, 2011, and before July 1, 2016), do not automatically report the full amount of the section 5503 award; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period.

For portions of cost reporting periods occurring during the 5-year evaluation period, if the amount reported on Worksheet S-2, Part I, line 61.02, column 2, is less than the amount on line 61.01, column 2, then report **zero (0)** on this line.

Line 8.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 8.03 through 8.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase. If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective. If the effective date of the cap increase is not the same as your fiscal year beginning date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period).

Line 9--Adjusted IME FTE Resident Cap--Enter the result of line 5 plus line 6, minus lines 7 and 7.01, plus or minus lines 8, 8.01, and 8.02, and applicable subscripts. However, if the resulting IME cap is less than zero (0), enter zero (0) on this line.

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Calculation of the allowable current year FTEs:

Line 10--Enter the FTE count for allopathic and osteopathic programs in the current year from your records. Do not include residents in the initial years of the new program, which, for urban or rural hospitals that participate in training residents in a new program under 42 CFR 413.79(e)(1) or (e)(3), prior to October 1, 2012, means that the program has not yet completed one cycle of the program (i.e., "period of years," or the minimum accredited length of the program). (*See* 42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).) For new programs started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years, see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012, under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on that new program. Therefore, for rural hospitals, do not include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that specific new program started (see 79 FR 50110 (August 22, 2014)). For both urban and rural hospitals, report FTE residents in the initial years of the new program on line 16. Exclude FTE residents displaced by hospital or program closure that are in excess of the cap for which a temporary cap adjustment is needed (*see* 42 CFR 412.105(f)(1)(v)).

Line 11--Enter the FTE count for residents in dental and podiatric programs.

Line 12--Enter the result of the lesser of line 9, or line 10 added to line 11.

Line 13--Enter the total allowable FTE count for the prior year, either from Form CMS-2552-96 line 3.14 or from Form CMS-2552-10 line 12, as applicable. Do not include residents in the initial years of the program that are exempt from the rolling average under 42 CFR 412.105(f)(1)(v). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 412.105(f)(1)(v)), enter on this line the allowable FTE count from line 12 plus the count of previously new FTE residents in that specific program that were added to line 16 of the prior year's cost report (line 3.17 if the prior year cost report was the Form CMS-2552-96). If you were not training any residents in approved teaching programs in the prior year, make no entry.

Line 14--Enter the total allowable FTE count for the penultimate year, either from Form CMS-2552-96 line 3.14, or Form CMS-2552-10 line 12, as applicable. If you were not training any residents in approved programs in the penultimate year, make no entry. Do not include residents in the initial years of the program that are exempt from the rolling average under 42 CFR 412.105(f)(1)(v). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 412.105(f)(1)(v)), enter on this line the allowable FTE count from line 12 plus the count of previously new FTE residents in that specific program that were added to line 16 of the penultimate year's cost report (line 3.17 if the prior year cost report was the Form CMS-2552-96).

Line 15--Enter the sum of lines 12 through 14 divided by three.

Line 16--Enter the number of FTE residents in the initial years of the program (*see* 42 CFR 412.105(f)(1)(v).) This line is reserved for use only by urban hospitals that do not have a previous FTE cap established on line 5 or line 6, and are first establishing an FTE cap by participating in training residents in a new allopathic or osteopathic residency program(s) for the first time in accordance with 42 CFR 413.79(e)(1). (Rural hospitals participating in training residents in new programs in accordance with 42 CFR 413.79(e)(3) would also report FTE residents in the initial years of the new program on this line). For a new program started prior to

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October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012, under 42 CFR 413.79(e)(3), include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that new program (see 79 FR 50110 (August 22, 2014)).

Line 17--Enter the additional FTEs for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment (see 42 CFR 412.105(f)(1)(v)).

Line 18--Enter the sum of lines 15, 16 and 17.

Line 19--Enter the current year resident to bed ratio by dividing line 18 by line 4.

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the Form CMS-2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e) for a new program started prior to October 1, 2012, add to the numerator of the prior year intern and resident to bed ratio (i.e., line 12 of the prior cost report, which might be zero, if applicable), the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (line 16) (i.e., the period of years is the minimum accredited length of the program). For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, then divide line 16 of this cost report by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program on or after October 1, 2012, under 42 CFR 413.79(e)(3), for each new program started, if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of each particular new program, then add the amount from line 12 of the prior year (if greater than zero) and line 16 of this cost report, and divide the sum by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see 42 CFR 412.105(a)(1)(i)). If the hospital is participating in a valid emergency Medicare GME affiliation agreement under a §1135 waiver, and a portion of this cost report falls within the time frame covered by that emergency affiliation agreement, then, effective on and after October 1, 2008, enter the current year resident-to-bed ratio from line 19 (see 73 FR 48649 (August 19, 2008) and 42 CFR 412.105(f)(1)(vi)). Effective for cost reporting periods beginning on or after October 1, 2002, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (see 42 CFR 412.105(a)(1)(iii)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17.

Line 21--Enter the lesser of *line* 19 or 20.

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IME Add-on Payment For SCHs--Effective for cost reporting periods beginning on or after October 1, 2014, all SCHs that are subsection (d) teaching hospitals will receive an IME add-on payment for discharges of Medicare Part C (managed care) patients in accordance with the 79 FR 50004 (August 22, 2014), regardless of whether the SCH is paid based on the federal rate or the hospital specific rate. For purposes of the comparison of payments based on the federal rate and the hospital specific rate, Medicare Part C patients will no longer be included as part of the federal rate payment.

Line 22--For cost reporting periods beginning before October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{((1 + \text{line 21}) \text{ to the } .405 \text{ power}) - 1\}$ times $\{\text{the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and 3}\}$.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{((1 + \text{line 21}) \text{ to the } .405 \text{ power}) - 1\}$ times $\{\text{the sum of lines 1.01, 1.02, 1.03, and 1.04}\}$.

Line 22.01--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{((1 + \text{line 21}) \text{ to the } .405 \text{ power}) - 1\}$ times line 3.

IME Adjustment Calculation for the Add-on--Computation of IME payments for additional allopathic and osteopathic resident cap slots received under 42 CFR 412.105(f)(1)(iv)(C)(1)--Complete lines 23 through 28 only where the amount on line 23 is greater than zero (0).

Line 23--Section 422 IME FTE Cap--Enter the number of allopathic and osteopathic IME FTE residents cap slots the hospital received under 42 CFR 412.105(f)(1)(iv)(C)(1), section 422, of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA).

Line 24--IME FTE Resident Count Over the Cap--Subtract line 9 from line 10, and enter the result. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines 25 through 28.

Line 25--Section 422 Allowable IME FTE Resident Count--If the count on line 24 is greater than zero, enter the *lesser* of line 23 or line 24.

Line 26--Resident to Bed Ratio for Section 422--Divide line 25 by line 4.

Line 27--IME Adjustment Factor for Section 422 IME Residents--Enter the result of the following: $.66 \text{ times } [(\{1 + \text{line 26}\} \text{ to the } .405 \text{ power}) - 1]$.

Line 28--IME Add On Adjustment--For cost reporting periods beginning before October 1, 2014, enter the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and 3, multiplied by the factor on line 27. For cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03, and 1.04, multiplied by the factor on line 27.

Line 28.01--IME Add On Adjustment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 3, multiplied by the factor on line 27.

Line 29--Total IME Payment--Enter the sum of lines 22 and 28.

Line 29.01--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 22.01 and 28.01.

Disproportionate Share Adjustment--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share

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of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 30 through 34. Complete lines 33 and 34 only if you are an IPPS hospital and answered yes to line 22, column 1, of Worksheet S-2, Part I.

Line 30--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your contractor.)

Line 31--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus line 32, minus the sum of lines 5 and 6, plus employee discount days reported on line 30.

Line 32--Add lines 30 and 31, to equal the hospital's DSH patient percentage.

Line 33--Compare the percentage on line 32 with the criteria described in 42 CFR 412.106(c) and (d). Enter the payment adjustment factor calculated in accordance with 42 CFR 412.106(d). Hospitals qualifying for DSH in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, Part I, line 22, column 2, is "Y" for yes, enter 35.00 percent on line 33.

NOTE: For cost reporting periods ending on or after October 1, 2014, and before October 1, 2016, 42 CFR 412.102 provides for a 2-year transition to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic redesignation from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY 2015. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2015 and 1/3 of the difference between the urban and rural operating DSH for FY 2016. This affects providers that responded yes in column 1 or column 2, and yes in column 3 of Worksheet S-2, Part I, line 22.03. See 79 FR 49963 (August 22, 2014).

Line 34--Multiply line 33 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 33 times line 1.01), plus ((line 33 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 33 times the sum of lines 1.01 through 1.03) times 25 percent. For cost reporting periods that overlap or begin on or after October 1, 2014, enter the sum of {((line 33 times the sum of lines 1.01 and 1.03) times 25 percent), plus ((line 33 times the sum of lines 1.02 and 1.04) times 25 percent)}.

Section 3133 of the ACA provides that, for services occurring on or after October 1, 2013, a subsection (d) (i.e., IPPS hospital) hospital which is entitled to receive a DSH payment will receive two separately calculated payments. The "empirically justified Medicare DSH payment," which represents 25 percent of the amount the hospital would have received under 42 CFR 412.106(d), is calculated on line 34. The "additional payment for uncompensated care" payment is calculated on lines 35 through 36.

Uncompensated Care Adjustment--Section 3133 of the ACA: (1) provides that for discharges occurring on or after October 1, 2013, subsection (d) hospitals' Medicare DSH payments are reduced by 75 percent (to the empirically justified Medicare DSH payment); and (2) established an uncompensated care payment amount, which represents the remaining 75 percent of the DSH payments, and distributes a portion of this amount to each qualifying DSH hospital based on its share of uncompensated care. Effective for cost reporting periods overlapping or beginning on or after October 1, 2013, complete lines 35 through 36, columns 1 and 2, as applicable, only if you are a subsection (d) hospital and answered yes to Worksheet S-2, Part I, line 22, column 1.

If Worksheet S-2, Part I, line 22, column 1, is “Y” and Worksheet S-2, Part I, line 22.01, columns 1 and 2, are “Y”, do not complete lines 35 and 35.01. If Worksheet S-2, Part I, line 22.01, either column 1 or 2, is “N”, complete only the column with the “N” response for lines 35 and 35.01. A response of “Y” for both questions indicates that a hospital uncompensated care payment has been pre-determined for your hospital for the applicable FFY. For SCHs, if Worksheet S-2, Part I, line 22, column 1, is “Y” and Worksheet S-2, Part I, line 35, column 1, is greater than or equal to 1, complete lines 35 through 35.03, columns 1 and 2, as applicable.

NOTE: For cost reporting periods that overlap October 1, 2013, leave column 1 blank and complete only column 2. For cost reporting periods that begin on October 1, complete only column 2; however, when the cost reporting period begins on October 1, and overlaps October 1, of the subsequent year, complete column 1 for the first period (October 1, through September 30) and complete column 2 for the remainder of the cost reporting period.

Line 35--If Worksheet S-2, Part I, line 22, column 1, is “Y” and Worksheet S-2, Part I, line 22.01, column 1 or 2, is “N”, or Worksheet S-2, Part I, line 22, column 1, is “Y” and this is a newly merged DSH eligible hospital (Worksheet S-2, Part I, line 22.02, column 1 or 2, is “Y”), enter in the corresponding column the full amount (for all eligible IPPS hospitals) available for uncompensated care payments for the appropriate FFY. For example, for a cost reporting period ending December 31, 2013, enter zero in column 1 for the portion of the cost reporting period that began prior to October 1, 2013, and enter the FFY14 uncompensated care payment amount in column 2. The total uncompensated care payment amount for FFY 14 is \$9,046,380,143 and for FFY 15 is \$7,647,644,885. Subsequent total uncompensated care amounts should be obtained from the corresponding federal year IPPS final rule or correction notice, as applicable. If this is a SCH and Worksheet S-2, Part I, line 22, column 1, is “Y”, but an amount for line 35.02 was not determined by CMS for a FFY, complete this line accordingly.

Line 35.01--If Worksheet S-2, Part I, line 22.01, column 1 or 2, is “N”, enter the applicable Factor 3 value determined by CMS for uncompensated care payments for the appropriate FFY in columns 1 and 2. If this is a SCH and Worksheet S-2, Part I, line 22, column 1, is “Y”, but an amount for line 35.02 was not determined by CMS for a FFY, enter the applicable Factor 3 value determined by CMS for the appropriate FFY in column 1 and/or 2. If you are a new hospital (Worksheet S-2, Part I, line 47, column 2, is “Y”), or a newly merged DSH eligible hospital (Worksheet S-2, Part I, line 22.02, column 1 or 2, is “Y”), Factor 3 must be calculated. *Refer to the applicable FFY IPPS final rule for further information.* In determining Factor 3, the numerator is the *applicable* year cost report Medicaid days (Worksheet S-2, Part I, line 24, sum of columns 1 through 6) plus the SSI days published for the applicable FFY, divided by the denominator which is a fixed amount obtained from the applicable FFY IPPS rule. For FFY 14 the denominator is 36,429,747, for FFY 15 the denominator is 36,484,622, and for FFY 16 the denominator is 36,755,805 (the denominator represents the total IPPS hospitals’ Medicaid days and SSI days for the applicable FFY).

For FFY 17, a hospital’s Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2011, FY 2012, and FY 2013. The denominator for FY 2011 Factor 3 is 36,930,764; FY 2012 Factor 3 is 37,123,932, and FY 2013 Factor 3 *is* 37,302,359. If the hospital does not have data for one or more of the three cost reporting periods, compute Factor 3 for the periods available and average those by dividing the sum of the individual Factor 3s by the number of cost reporting periods for which there are data. Round Factor 3 to 9 decimal places.

For FFY 18, a hospital’s Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2012, FY 2013, and FY 2014. The denominator for FY 2012 Factor 3 is 37,065,316; FY 2013 Factor 3 is 37,311,194; and FY 2014 Factor 3 is based on uncompensated care costs of \$25,199,302,174. If the hospital does not have data for one or more of the three cost reporting periods, compute Factor 3 for the periods available and average those by dividing the sum of the individual Factor 3s by the number of cost reporting periods for which there are data. Round Factor 3 to 9 decimal places. *For FFY 18, the Medicaid days and uncompensated care costs are annualized.*

For FFY 19, a hospital's Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2013, FY 2014, and FY 2015. The denominator for FY 2013 Factor 3 is 37,539,919; FY 2014 Factor 3 is \$31,598,052,056; and FY 2015 Factor 3 is \$30,210,112,106. FY 2014 and FY 2015 are based on uncompensated care cost. If the hospital does not have data for one or more of the three cost reporting periods, compute Factor 3 for the periods available and average those by dividing the sum of the individual Factor 3s by the number of cost reporting periods for which there are data. Round Factor 3 to 9 decimal places. For FFY 19, the Medicaid days and uncompensated care costs are annualized.

Line 35.02--If Worksheet S-2, Part I, line 22, column 1, is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2, is "Y", enter the hospital uncompensated care payment amount determined by CMS for the appropriate FFY in columns 1 and 2. If Worksheet S-2, Part I, line 22, column 1, is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", or Worksheet S-2, Part I, line 22, column 1, is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", and Worksheet S-2, Part I, line 22.02, column 1 or 2, is "Y", then CMS did not determine the hospital uncompensated care payment amount for that FFY. Compute this amount by multiplying line 35 times line 35.01, for column 1 and column 2. If this is a SCH and Worksheet S-2, Part I, line 22, column 1, is "Y" but an amount for line 35.02 was not determined by CMS for a FFY, compute the amount by multiplying line 35 times line 35.01, for column 1 and column 2. If Worksheet S-2, Part I, line 22, column 1, is "N" and/or line 34 above is zero, enter zero on this line.

Line 35.03--Enter the pro rata share of the hospital's uncompensated care payment in columns 1 and 2. Enter in column 1, line 35.02, times the number of days in the cost reporting period prior to October 1, divided by the total days in the FFY. Enter in column 2, line 35.02, times the number of days in the cost reporting period on or after October 1, divided by the total days in the FFY.

For example, *for* a calendar year cost reporting period January 1, 2013, through December 31, 2013, enter zero in column 1, for the period of January 1, 2013, through September 30, 2013, *because* this period is prior to FFY 14 (*the UCC payment is effective beginning FFY 14*); enter in column 2, for the period of October 1, 2013, through December 31, 2013 (FFY 14), *the result of* 92 days *divided by* 365 days in FFY 14, *multiplied by* line 35.02, column 2.

As another example, *for* a calendar year cost reporting period of January 1, 2014, through December 31, 2014, enter in column 1, for the period of January 1, 2014, through September 30, 2014 (FFY 14), *the result of* 273 days *divided by* 365 days in FFY 14, *multiplied by* line 35.02, column 1; enter in column 2, for the period of October 1, 2014, through December 31, 2014 (FFY 15), *the result of* 92 days *divided by* 365 days in FFY 15, *multiplied by* line 35.02, column 2.

For SCH/MDH status changes, use subscripted lines 35.04 and 35.05. For SCH or MDH status changes, subscript column 1, for any portion of the cost reporting period under IPPS status.

Lines 35.04--For portions of the cost reporting period under MDH status, enter in columns 1 and 2, the pro rata share of the hospital's uncompensated care payment amounts reported on line 35.03, columns 1 and 2. For any portion of the cost reporting period under IPPS, enter the pro rata share of the hospital's uncompensated care payment amounts reported on line 35.03, columns 1 and 2, in subscripted column 1.01.

Lines 35.05--For portions of the cost reporting period under SCH status, enter in columns 1 and 2, the pro rata share of the hospital's uncompensated care payment amounts reported on line 35.03, columns 1 and 2. For any portion of the cost reporting period under IPPS, enter the pro rata share of the hospital's uncompensated care payment amounts reported on line 35.03, columns 1 and 2, in subscripted column 1.01.

For example, a hospital with a 2015 calendar year cost reporting period loses its MDH status on October 15, 2015. Enter on line 35.04, column 1, for the period of January 1, 2015, through September 30, 2015, the uncompensated care payment amount from line 35.03, column 1. Enter on line 35.04, column 1.01, the pro rata share of the uncompensated care payment amount from

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line 35.03, column 2 (IPPS status for the period of October 15, 2015, through December 31, 2015), ((78 days/365 days) times line 35.03, column 2). Enter on line 35.04, column 2, the pro rata share of the uncompensated care payment amount from line 35.03, column 2, (MDH status for the period of October 1, 2015, through October 14, 2015), ((14 days/365 days) times line 35.03, column 2).

Line 36--Enter the hospital's uncompensated care adjustment amount (the sum of columns 1 and 2, line 35.03).

Lines 37 through 39--Reserved for future use.

Additional Payment for High Percentage of ESRD Beneficiary Discharges--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. When the average weekly cost per dialysis treatment changes within a cost reporting period, create an additional column (column 1.01) for lines 41 and 45.

Line 40--Enter total Medicare discharges excluding discharges for MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48447 and 48520 (August 19, 2008)). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see 76 FR 51693 (August 18, 2011)) for all Medicare beneficiaries entitled to Medicare Part A. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under §1876 of the Act (HMOs), and competitive medical plans (CMPs). These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the denominator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.

Line 41--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see 69 FR 49087 (August 11, 2004)) excluding MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48520 and 48447 (August 19, 2008)). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see 76 FR 51693 (August 18, 2011)) for all ESRD Medicare beneficiaries entitled to Medicare Part A who receive inpatient dialysis. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under §1876 of the Act (HMOs), and CMPs. These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the numerator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.

Line 41.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see 69 FR 49087 (August 11, 2004)) excluding MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48520 and 48447 (August 19, 2008)). The discharges on this line are associated with Medicare covered and paid hospital stays, and are included in the discharges in Worksheet S-3, Part I, column 13, line 14. These discharges are a subset of the discharges on line 41. The discharges on this line are only used to determine the ESRD add-on payment, not eligibility for the add-on payment.

Line 42--Divide line 41, sum of columns 1 and 1.01 by line 40. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 43--Enter the total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684, and 685, as applicable. The Medicare ESRD inpatient days must be included in the Medicare inpatient days reported in Worksheet S-3, Part I, column 6, line 14, and are part of a Medicare covered stay.

Line 44--Enter the average length of stay expressed as a ratio to 7 days. For cost reporting periods ending before June 30, 2014, divide line 43 by line 41, sum of columns 1 and 1.01, and divide that result by 7 days. For cost reporting periods ending on or after June 30, 2014, divide line 43 by line 41.01, sum of columns 1 and 1.01, and divide that result by 7 days.

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Line 45--Enter the average weekly cost per dialysis treatment calculated by multiplying the unadjusted composite rate per treatment by 3. For example, the average weekly cost per dialysis treatment for CY 2013 is \$435.60 (\$145.20 times the average weekly number of treatments of 3). This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Line 46--For cost reporting periods ending before June 30, 2014, enter the ESRD payment adjustment (line 44, column 1, times line 45, column 1, times line 41, column 1, plus, if applicable, line 44, column 1, times line 45, column 1.01, times line 41, column 1.01). For cost reporting periods ending on or after June 30, 2014, enter the ESRD payment adjustment (line 44, column 1, times line 45, column 1, times line 41.01, column 1, plus, if applicable, line 44, column 1, times line 45, column 1.01, times line 41.01, column 1.01).

Line 47--Enter the sum of lines 1, 1.01, 1.02, 2, 2.01, 2.02, **2.03**, **2.04**, 29, 34, 36, and 46.

Line 48--SCHs are paid the highest of the federal payment rate, the hospital-specific rate (HSR) determined based on a FFY 1982 base period (see 42 CFR 412.73), the hospital-specific rate determined based on a FFY 1987 base period (see 42 CFR 412.75), for cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate determined based on a FFY 1996 base period (see 42 CFR 412.77), or for cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate determined based on a FFY 2006 base period (see 42 CFR 412.78). MDHs are paid the highest of the federal payment rate, or the federal rate plus 75 percent of the amount of the excess over the federal rate of the highest rate for the 1982, 1987, or 2002 (see 42 CFR 412.79), base period hospital specific rate. Effective January 1, 2016, former MDHs that lost their MDH status because they are no longer in a rural area due to the new OMB delineations in FY 2015 (Worksheet S-2, Part I, line 37.01, is yes) will transition from payments based, in part, on the hospital-specific rate to payments based entirely on the Federal rate. For discharges occurring on or after January 1, 2016, and before October 1, 2016, these former MDHs will receive the Federal rate plus two-thirds of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital's hospital-specific rate payment. For FY 2017, that is, for discharges occurring on or after October 1, 2016, and before October 1, 2017, these former MDHs will receive the Federal rate plus one-third of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital's hospital-specific rate. For FY 2018, that is, for discharges occurring on or after October 1, 2017, these former MDHs will be paid based solely on the Federal rate. For SCHs, MDHs and former MDHs, enter the applicable hospital-specific payments.

For SCHs only, the hospital-specific payment amount entered on this line is supplied by your contractor. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. Use the hospital specific rate based on the higher of the cost reporting periods beginning in FFY 1982, 1987, or 1996.

Additionally, for SCHs only (effective for cost reporting periods beginning on or after January 1, 2009), use the highest of the determined hospital specific rate based on FFY 1982, 1987, 1996, or 2006.

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2022, an MDH can use a FFY 2002 hospital specific rate. The MDH program ends on September 30, 2022.

Line 49--For SCHs, enter the greater of line 47 or 48, plus the amount from line 29.01. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2022, if line 47 is greater than line 48, enter the amount on line 47, plus the amount from line 29.01. For MDHs, if line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47, plus the amount from line 29.01. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47, plus the amount from line 29.01.

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For former MDHs (Worksheet S-2, Part I, line 37.01, is yes), effective for cost reporting periods that begin or overlap January 1, 2016, if line 48 is greater than line 47, enter the amount on line 47, plus two-thirds of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period between January 1, 2016, and September 30, 2016, divided by the total number of days in the cost reporting period)), plus the amount from line 29.01. For cost reporting periods that begin or overlap October 1, 2016, if line 48 is greater than line 47, enter the amount on line 47, plus two-thirds of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period prior to October 1, 2016, divided by the total number of days in the cost reporting period)), plus one-third of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period beginning on or after October 1, 2016, and before October 1, 2017, divided by the total number of days in the cost reporting period)), plus the amount from line 29.01.

For hospitals subscribing column 1 of line 47 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

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Line 50--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 12, or Part II, line 5, as applicable.

Line 51--Enter the special exceptions payment for inpatient program capital, if applicable pursuant to 42 CFR 412.348(f) by entering the result of Worksheet L, Part III, line 13, less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 52--Enter the amount from Worksheet E-4, line 49. Complete this line only for the hospital component.

Obtain the payment amounts for lines 53 and 54 from your contractor.

Line 53--Enter the amount of nursing and allied health managed care payments, if applicable.

Line 54--Enter the special add-on payment for new technologies (see 42 CFR 412.87 and 412.88). Include in the add-on payment for new technologies payments associated with Model 4 BPCI.

Line 54.01--Enter the special add-on payment for islet isolation cell transplantation (see CR 9570).

Line 55--Enter the net organ acquisition cost from Worksheet(s) D-4, Part III, column 1, line 69.

Line 56--Teaching hospitals or sub-providers electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 57--Enter the routine service other pass-through costs from Worksheet D, Part III, column 9, lines 30 through 35 for the hospital.

Line 58--Enter the ancillary service other pass-through costs from Worksheet D, Part IV, column 11, line 200.

Line 59--Enter the sum of lines 49 through 58.

Line 60--Enter the amounts paid or payable by workers' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 60. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it

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otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 60 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 60.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-4, Part III, line 66.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass-through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 60 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 61--Enter the result of line 59 minus line 60.

Line 62--Enter, from the PS&R or your records, the deductibles billed to program patients excluding deductibles and coinsurance associated with Model 4 BPCI payments.

Line 63--Enter, from the PS&R or your records, the coinsurance billed to program patients excluding deductibles and coinsurance associated with Model 4 BPCI payments.

Line 64--Enter the program allowable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 64 and 65 will be negative. (See CMS Pub. 15-1, chapter 3).

Line 65--Enter the result of line 64 (including negative amounts) times 70 percent for cost reporting periods that begin prior to October 1, 2012. For cost reporting periods that begin on or after October 1, 2012, enter the result of line 64 times 65 percent.

Line 66--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 64.

Line 67--Enter the sum of lines 61 and 65, minus the sum of lines 62 and 63.

Line 68--Enter, from the PS&R, the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in the IPPS final rule for the applicable cost reporting period. (See CMS Pub. 100-04, chapter 3, §100.8.)

Line 69--Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95, and 96.

For SCHs, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.

Line 70--Enter any other adjustments. Specify the adjustment in the space provided. Hardcoded subscripts of this line are identified as such.

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Line 70.50--Enter the §410A rural community hospital demonstration project payment adjustment amount from line 218, column 1.

Line 70.87--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R. Do not include demonstration payment adjustment amounts reported on lines 70.50 and 70.89.

Line 70.88--Contractor use only: Enter the volume decrease adjustment for SCH or MDH hospitals in accordance with 42 CFR 412.92(e) or 412.108(d), respectively.

Line 70.89--Enter the Pioneer Accountable Care Organization (ACO) demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 70.87 or line 71.02, accordingly.

Line 70.90--For MDH use only. Enter the hospital value-based purchasing (HVBP) adjustment amount relative to the HSP bonus payment from line 102, sum of columns 1 and 2.

Line 70.91--For MDH use only. Enter the hospital readmission reduction (HRR) adjustment amount relative to the HSP bonus payment from line 104, columns 1 and 2.

Line 70.92--Enter the discount amount for the bundled payments for care improvement initiative (also referred to as Model 1) in accordance with ACA 2010, §3023, effective for discharges occurring on or after October 1, 2013. This demonstration actually began April 1, 2013; however, the discounted payments begin October 1, 2013. Obtain this amount from the PS&R. Do not change the sign of the amount displayed on the PS&R.

Line 70.93--Enter the payment adjustment amount for the HVBP program in accordance with ACA 2010, §3001, effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.94--Enter the adjustment amount resulting from the HRR program in accordance with ACA 2010, §3025, effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.95--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136-136.16, and 42 CFR 413.134(d)(3)(i).)

Line 70.96 through 70.98 (lines 70.96 and 70.97 are hardcoded)--Effective for discharges occurring during FFYs 2011 through **2018**, the low volume payment adjustment is determined in accordance with 42 CFR 412.101(c)(2). *Effective for discharges occurring during FFYs 2019 through 2022, the low volume payment adjustment is determined in accordance with 42 CFR 412.101(c)(3).* Effective for discharges occurring during FFY **2023** and subsequent years the low volume payment adjustment is determined in accordance with 42 CFR 412.101(c)(1).

For cost reporting periods that are concurrent with the FFY (October 1, through September 30), use line 70.97 only. For cost reporting periods that overlap October 1, enter on lines 70.96 (low-volume adjustment (enter the corresponding federal year for the period prior to October 1)) and line 70.97 (low-volume adjustment (enter the corresponding federal year for the period ending on or after October 1)), and, if necessary, line 70.98 (low-volume adjustments for additional portions of the cost reporting period, if necessary), the Medicare inpatient payment adjustment for low-volume hospitals as applicable in accordance with Exhibit 4 (low-volume adjustment calculation schedule and corresponding instructions).

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Line 70.99--Enter the HAC program payment reduction adjustment amount effective for discharges occurring on or after October 1, 2014. Use Exhibit 5 or similar worksheet to reconcile the HAC payment adjustment amount.

Line 71--Enter the result of line 67 plus the sum of lines 69, 70 through 70.86, 70.88, 70.90, 70.91, 70.92, 70.93, 70.94, and 70.96 through 70.98; minus the sum of lines 68, 70.87, 70.89, 70.95, and 70.99.

Line 71.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 71]. Do not apply the sequestration calculation when gross reimbursement is less than zero.

Line 71.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 72--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For contractor final settlements, enter the amount reported on Worksheet E-1, column 2, line 5.99, on line 73. Included in the interim payments are the amounts received as the estimated nursing and allied health managed care payments and capital, IME, DSH, and outlier payments associated with Model 4 BPCI.

Line 74--Enter line 71 minus the sum of lines 71.01, 71.02, 72, and 73. Transfer to Worksheet S, Part III.

Line 75--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 76 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

LINE 90 THROUGH 96 ARE FOR CONTRACTOR USE ONLY.

Line 90--*For cost reporting periods beginning before October 1, 2018, enter* the original operating outlier amount from line 2, sum of all columns of this Worksheet E, Part A, prior to the inclusion of lines 92, 93, 95, and 96, of Worksheet E, Part A. *For cost reporting periods beginning on or after October 1, 2018, enter the sum of the original operating outlier amounts from lines 2.03 and 2.04, sum of all columns of this Worksheet E, Part A, prior to the inclusion of lines 92, 93, 95, and 96, of Worksheet E, Part A.*

Line 91--Enter the original capital outlier amount from Worksheet L, Part I, line 2.

Line 92--Enter the operating outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5-20.1.2.7.

Line 93--Enter the capital outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5-20.1.2.7.

Line 94--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §§20.1.2.5-20.1.2.7.)

Line 95--Enter the operating time value of money for operating related expenses.

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Line 96--Enter the capital time value of money for capital related expenses.

Hospital Specific Payment (HSP) Bonus Payment HVBP Adjustment and HRR Adjustment--The ACA 2010 §§3001 and 3025 implemented HVBP and HRR and applied special rules for MDHs through FFY 13. Effective for discharges occurring on or after October 1, 2013, MDHs that receive a HSP bonus payment on the cost report are subject to a HVBP and HRR adjustment for that bonus payment amount. The HSP bonus payment amount is 75 percent of the amount that line 48 exceeds line 47. Complete lines 100 through 104 only when line 48 exceeds line 47.

For a former MDH (Worksheet S-2, Part I, line 37.01, is yes), for FY 2016 the HSP bonus payment amount determined for the period of January 1, 2016, through September 30, 2016, is two-thirds of 75 percent of the amount by which line 48 exceeds line 47. For FY 2017, the HSP bonus payment amount determined for the period of October 1, 2016, through September 30, 2017, is one-third of 75 percent of the amount by which line 48 exceeds line 47.

NOTE: For cost reporting periods that overlap October 1, 2013, leave column 1 blank and complete only column 2. For cost reporting periods that begin on October 1, complete only column 2.

Line 100--If line 48 is greater than line 47, enter the pro rata share of the HSP bonus payment amount in columns 1 and 2. Enter in column 1, $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period})\}$. Enter in column 2, $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period})\}$. If the hospital does not have MDH status for the entire cost reporting period, prorate accordingly.

For former MDHs for FY 2016, for cost reporting periods that begin on or after January 1, 2016, enter in column 1, two-thirds of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after January 1, 2016, through September 30, 2016, divided by the total days in the cost reporting period})\}$. Enter in column 2, one-third of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period})\}$. For cost reporting periods that overlap January 1, 2016, and end on or before September 30, 2016, enter zero in column 1, and enter in column 2, two-thirds of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after January 1, 2016, through September 30, 2016, divided by the total days in the cost reporting period})\}$. For cost reporting periods that overlap January 1, 2016, and October 1, 2016, enter in column 1, two-thirds of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after January 1, 2016, through September 30, 2016, divided by the total days in the cost reporting period})\}$. Enter in column 2, one-third of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period})\}$.

For former MDHs for FY 2017, for cost reporting periods that begin October 1, 2016, enter in column 2, one-third of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period})\}$. For cost reporting periods that overlap October 1, 2016, enter in column 1, two-thirds of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period prior to October 1, 2016, divided by the total days in the cost reporting period})\}$. Enter in column 2, one-third of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period})\}$. For cost reporting periods that overlap September 30, 2017, enter in column 1, one-third of $\{((\text{line 48 minus line 47}) \times 75 \text{ percent}) \times (\text{the number of days in the cost reporting period between October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period})\}$ and zero in column 2.

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Line 101--Enter the HVBP adjustment factor that corresponds to the portion of the cost reporting period prior to October 1, in column 1 and the HVBP adjustment factor that corresponds to the portion of the cost reporting period on or after October 1, in column 2. The HVBP adjustment factors are published annually in the IPPS final rule and posted on the CMS website. Enter "1" if the provider is not subject to the HVBP adjustment.

Line 102--The HVBP adjustment amount is computed as ((HSP Bonus x HVBP adjustment factor)-HSP Bonus). Enter in column 1, the HVBP adjustment amount for the portion of the cost reporting period prior to October 1, by multiplying (column 1, line 100, times column 1, line 101), minus column 1, line 100. Enter in column 2, the HVBP adjustment amount for the portion of the cost reporting period on or after October 1, by multiplying (column 2, line 100, times column 2, line 101) minus column 2, line 100.

Line 103--Enter the HRR adjustment factor that corresponds to the portion of the cost reporting period prior to October 1, in column 1, and HRR adjustment factor that corresponds to the portion of the cost reporting period on or after October 1, in column 2. The HRR adjustment factors are published annually in the IPPS final rule and posted on the CMS website. Enter "1" if the provider is not subject to the HRR adjustment.

Line 104--The HRR adjustment amount is computed as ((HSP Bonus x HRR adjustment factor)-HSP Bonus). Enter in column 1, the HRR adjustment amount for the portion of the cost reporting period prior to October 1, by multiplying (column 1, line 100, times column 1, line 103) minus column 1, line 100. Enter in column 2, the HRR adjustment amount for the portion of the cost reporting period on or after October 1, by multiplying (column 2, line 100, times column 2, line 103) minus column 2, line 100.

Rural Community Health Demonstration Project (§410A Demonstration) Adjustment--For cost reporting periods ending on or after September 30, 2017, lines 200 through 218 provide for the calculation of the §410 Demonstration project adjustment in accordance with the MMA of 2003, §410A, and extended under §§3123 and 10313 of the ACA 2010, and §15003 of the 21st Century Cures Act of 2016. Complete the applicable lines if Worksheet S-2, Part I, line 110, is "Y," and calculate line 201 based on reasonable cost at 100% (not 101%).

A hospital participating in the §410A Demonstration receives payment for inpatient hospital services furnished to Medicare beneficiaries, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules: a) For discharges occurring in the first cost reporting period on or after the implementation of the extension, their reasonable costs of providing covered inpatient hospital services; b) For discharges occurring during the second and subsequent cost reporting periods, the lesser of their reasonable costs or a target amount. The target amount for the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the IPPS update factor (as defined in section 1886(b)(3)(B)) for that particular cost reporting period. The target amount for each subsequent cost reporting period is defined as the preceding cost reporting period's target amount increased by the IPPS update factor for that particular cost reporting period.

Line 200--Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.

Line 201--Enter the Medicare inpatient service costs from Worksheet D-1, Part II, line 49.

Line 202--Enter the Medicare discharges from Worksheet S-3, column 13, line 1.

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Line 203--Enter the case-mix adjustment factor (four-decimal places) used to update the target amount for years 2 through 5. Obtain the update factor from the contractor.

Line 204--Enter the Medicare target amount per discharge. Obtain the target amount per discharge from the contractor.

Line 205--Enter the case-mix adjusted target amount for years 2 through 5, determined by multiplying line 203 times line 204.

Line 206--Enter the Medicare inpatient routine cost cap determined by multiplying line 202 times line 205.

Line 207--Enter the Program reimbursement as determined under the §410A Demonstration as follows: For the first year of the current 5-year demonstration period, enter the amount from line 201. For the subsequent years of the current 5-year demonstration period, enter the lesser of line 201 or line 206.

Line 208--Enter the Medicare Part A inpatient service costs for Medicare beneficiaries from Worksheet E, Part A, line 59.

Line 209--Enter the adjustment to Medicare IPPS payments (the difference between reimbursement under IPPS and cost reimbursement under the §410A Demonstration). Enter the result of line 207 minus line 208.

Line 210--This line is reserved for future use.

Line 211--Enter the total adjustment to the Medicare IPPS payment. Enter the total amount from line 209.

Line 212--Enter the total adjustment to the Medicare Part A IPPS payment from line 211.

Line 213--Enter the low volume adjustment payments from Worksheet E, Part A, lines 70.96, 70.97, and 70.98, as applicable.

Lines 214 through 217--Reserved for future use.

Line 218--Enter the net adjustment to the Medicare Part A IPPS payment, the difference between the IPPS payment and the cost reimbursement under the rural community hospital demonstration project, by subtracting the amount on line 213 from the amount on line 212. Transfer the amount in column 1 to line 70.50.

Instructions for Completing Exhibit 4--Low-Volume Adjustment Calculation Schedule:

42 CFR 412.101 provides for a low-volume adjustment for Medicare discharges in qualifying hospitals. The amount of any adjustment depends on the FFY in which the discharges occur.

42 CFR 412.101(c)(1) provides for the low-volume adjustment for Medicare discharges in FFYs 2005 through 2010 (discharges on and after October 1, 2004, and before October 1, 2010), and FFY 2023, and subsequent FFYs (discharges on and after October 1, 2022). Qualifying hospitals, those hospitals more than 25 road miles from the nearest subsection (d) hospital and with fewer than 200 discharges, receive a payment adjustment of an additional 25 percent for each Medicare discharge.

42 CFR 412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011 through 2018 (discharges on and after October 1, 2010, and before October 1, 2018). Qualifying hospitals, those hospitals more than 15 road miles from the nearest subsection (d) hospital and with fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data, receive a payment adjustment as follows:

- Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each discharge; and
- Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula $[(4/14) - (\text{Medicare discharges}/5,600)]$.

42 CFR 412.101(c)(3) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2019 through 2022 (discharges on and after October 1, 2018, and before October 1, 2022). Qualifying hospitals, those hospitals more than 15 road miles from the nearest subsection (d) hospital and with fewer than 3,800 total discharges based on the hospital's most recently submitted cost report, receive a payment adjustment as follows:

- *Those hospitals with 500 or fewer total discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and,*
- *Those with more than 500 and fewer than 3,800 total discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula $[(95/330) - (\text{total discharges}/13,200)]$.*

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CMS provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges and their low-volume percentage add-on, if applicable, for FFYs 2011 through 2018 (discharges before October 1, 2018). However, this list is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criteria. Hospitals were required to request low-volume status in writing to their contractor and provide documentation that they met the mileage criteria.

The low-volume payment adjustment for eligible hospitals is based on their total per discharge payments made under § 1886 of the Act, including the capital IPPS payments, DSH payments, IME payments, and outlier payments. For SCHs and MDHs, the low-volume payment adjustment for eligible hospitals is based on either the federal rate or the hospital-specific payment (HSP) rate, whichever results in a greater operating IPPS payment. The low-volume payment amount calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during year end cost report settlement if any of the payment amounts upon which the low-volume payment amount is based are also recalculated at cost report settlement (for example, payments for DSH and IME or federal rate versus HSP rate payments for SCHs and MDHs).

NOTE: Because a hospital's eligibility for the low-volume payment adjustment and/or a hospital's applicable low-volume adjustment percentage can change during its cost reporting period (for example, a hospital with a cost report that spans the start of the FFY), it is necessary to determine the low-volume payment amount using the applicable low-volume adjustment percentage for the FFY and payment amounts listed above for a hospital's discharges that occur during the FFY for each FFY included by the hospital's cost reporting period.

After the cost report is calculated for settlement, the low-volume payment adjustment must be calculated. The low-volume payment amount must be calculated by FFY. Therefore, if the cost report overlaps a FFY, the information computed on Worksheet E, Part A, must be recomputed by FFY accordingly. The amounts may not be prorated, but must be calculated using the appropriate information. The following payment amounts are multiplied by the low-volume payment adjustment percentage by FFY:

- Operating Federal IPPS payments;
- Operating HSR payments;
- Operating outlier payments including any Operating Outlier Reconciliation amounts;
- Operating IME payments;
- Operating IME payments for Medicare Advantage patients;
- Operating DSH payments;
- Uncompensated care payments;
- ESRD adjustment payments;
- Total Capital IPPS payment;
- New technology payments;
- Credits for replaced devices; and
- Capital outlier reconciliation amounts (if applicable, see instructions)

Complete Exhibit 4 to compute the low-volume adjustment payment applicable to this cost reporting period. **The Exhibit 4 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated.**

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A, and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A, and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

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Column 2--Enter amounts related to discharges occurring in the cost reporting period either pre-entitlement (discharges occurring in the cost reporting period prior to October 1) or post-entitlement (discharges occurring in the cost reporting period on or after October 1). Discharges occurring in these periods are not eligible for the low-volume adjustment.

In addition, if there are discharges occurring during this cost reporting period and the provider was not eligible for the low-volume adjustment for the entire eligibility period, report the information relative to those discharges in this column, for example, where a provider has a cost reporting period ending June 30, 2011, which began prior to the October 1, 2010, effective date of the provision. Or where the low-volume adjustment for discharges occurring in this cost reporting period is effective for discharges on or after October 1, 2010; however, the provider did not request the low-volume adjustment until November 15, 2010, and the low-volume adjustment was implemented within 30 days of the request. The period of time from October 1, 2010, until the contractor notified the provider of eligibility, which should be no later than December 15, 2010, is considered a period of ineligibility.

Column 3--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and prior to October 1. If the cost reporting period is not concurrent with a federal year of October 1, through September 30, do not include discharges occurring on or after October 1, in this column.

If the provider goes in and out of eligibility for discharges occurring prior to October 1, add all discharges for the eligibility periods prior to October 1, and include in this column. If the provider's classification (i.e. SCH to small rural) changes during the eligibility period, use subscripted column 3.01 to accommodate the change for discharges occurring prior to October 1.

Column 4--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and on or after October 1. If the cost reporting period is concurrent with a federal year of October 1, through September 30, report all discharges occurring on or after October 1, in this column. If the provider goes in and out of eligibility for discharges occurring on or after October 1, add all discharges for the eligibility periods on or after October 1, and include in this column. If the provider's classification (i.e. SCH to small rural) changes during the eligibility period, use subscripted column 4.01 to accommodate the change for discharges occurring on or after October 1.

Columns 3, 3.01, 4, and 4.01--Use the beginning and ending dates of the applicable portion of the cost reporting period as the respective column headings.

Column 5--Subtotal columns 2 through 4, and applicable subscripts. Column 5 must equal column 1, and any resulting rounding difference must be applied to the highest value in columns 2 through 4, and applicable subscripts.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the federal operating portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 1.01 (Corresponds to Worksheet E, Part A, line 1.01)--Enter the DRG amounts other than outlier payments for discharges occurring prior to October 1, in column 3.

Line 1.02 (Corresponds to Worksheet E, Part A, line 1.02)--Enter the DRG amounts other than outlier payments for discharges occurring on or after October 1, in column 4.

Line 1.03 (Corresponds to Worksheet E, Part A, line 1.03)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and

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reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report. Effective for cost reporting periods that overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1, in columns 2 and 3 accordingly.

Line 1.04 (Corresponds to Worksheet E, Part A, line 1.04)--Enter the DRG for federal specific operating payments for Model 4 BPCI occurring on or after October 1, on this line. The PS&R information must be split and reported in columns 2 and 4 accordingly, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report. *For cost reporting periods beginning on or after October 1, 2018, do not complete this line, but complete lines 2.02 and 2.03.*

Line 2.01 (Corresponds to Worksheet E, Part A, line 2.02)--Enter the outlier payment for discharges for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2.02 (Corresponds to Worksheet E, Part A, line 2.03)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring prior to October 1, in column 3.

Line 2.03 (Corresponds to Worksheet E, Part A, line 2.04)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring on or after October 1, in column 4.

Line 3 (Corresponds to Worksheet E, Part A, line 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92, for each respective period. The lump sum utility produces a claim-by-claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the contractor must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the FFYs spanned by the cost report separately. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, line 3)--Enter the IME for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care "simulated payments" from the PS&R. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 5 (Corresponds to Worksheet E, Part A, line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 through 4.

Line 6 (Corresponds to Worksheet E, Part A, line 22)--For cost reporting periods beginning before October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{(1 + \text{line 5}) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and line 4}\}$. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 22.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{(1 + \text{line 5}) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of lines 1.01, 1.02, 1.03 and 1.04}\}$.

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Line 6.01 (Corresponds to Worksheet E, Part A, line 22.01)--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{(1 + \text{line 5}) \text{ to the } .405 \text{ power} - 1\}$ times line 4.

Line 7 (Corresponds to Worksheet E, Part A, line 27)--Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 through 4.

Line 8 (Corresponds to Worksheet E, Part A, line 28)--IME Add On Adjustment--For cost reporting periods beginning before October 1, 2014, enter the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and 4, multiplied by the factor on line 7.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03 and 1.04, multiplied by the factor on line 7.

Line 8.01 (Corresponds to Worksheet E, Part A, line 28.01)--IME Add On Adjustment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.

Line 9.01 (Corresponds to Worksheet E, Part A, line 29.01)--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 6.01 and 8.01. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.01.

Line 10 (Corresponds to Worksheet E, Part A, line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 through 4.

Line 11 (Corresponds to Worksheet E, Part A, line 34)--Multiply line 10 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of $\{(\text{line 10 times line 1.01}), \text{plus } ((\text{line 10 times the sum of lines 1.02 and 1.03}) \text{ times } 25 \text{ percent})\}$. For cost reporting periods beginning on or after October 1, 2013, multiply (line 10 times the sum of lines 1.01, 1.02, and 1.03) times 25 percent. For cost reporting periods overlapping or beginning on or after October 1, 2014, multiply (line 10 times the sum of lines 1.01, 1.02, 1.03, and 1.04) times 25 percent. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 34.

Line 11.01 (Corresponds to Worksheet E, Part A, line 36)--Enter the uncompensated care payments. For cost reporting periods that overlap or begin on or after October 1, 2013, when you are eligible for the low-volume payment adjustment for the entire cost reporting period, enter in column 3, the uncompensated care payments from Worksheet E, Part A, column 1, line 35.03, and enter in column 4, the uncompensated care payments from Worksheet E, Part A, column 2, line 35.03.

For cost reporting periods that overlap or begin on or after October 1, 2013, when you are not eligible for the low-volume payment adjustment for any portion of the cost reporting period, enter the uncompensated care payments as follows:

- Enter in column 3, the uncompensated care payment eligible for the low-volume payment adjustment for the portion of the cost reporting period prior to October 1, (calculated as the amount from Worksheet E, Part A, column 1, line 35.03, times the ratio of the number of days prior to October 1, in the cost reporting period eligible for the low-volume payment adjustment divided by the total days in the cost reporting period prior to October 1).

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- Enter in column 4, the uncompensated care payment eligible for the low-volume payment adjustment for the portion of the cost reporting period on and after October 1 (calculated as the amount from Worksheet E, Part A, column 2, line 35.03, times the ratio of the number of days on and after October 1, in the cost reporting period eligible for the low-volume payment adjustment divided by the total days in the cost reporting period on and after October 1).
- Enter in column 2, the uncompensated care payments not eligible for the low-volume payment adjustment (calculated as the total uncompensated care payment, from Worksheet E, Part A, line 35.03, sum of columns 1 and 2, minus the sum of the uncompensated care payments reported in columns 3 and 4 of this exhibit). The sum of columns 2 through 4, must equal Worksheet E, Part A, line 36.

Line 12 (Corresponds to Worksheet E, Part A, line 46)--Prorate in columns 2 through 4, the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, line 47)--Enter the sum of lines 1, 1.01, 1.02, 2, 2.01, **2.02, 2.03**, 3, 9, 11, 11.01, and 12. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 47.

Line 14 (Corresponds to Worksheet E, Part A, line 48)--For SCHs and MDHs, enter the applicable hospital-specific payments. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 48. If Worksheet E, Part A, line 47, is greater than Worksheet E, Part A, line 48, do not complete this line.

Line 15 (Corresponds to Worksheet E, Part A, line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount reported on line 14, plus the amount from line 9.01, for each applicable column. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2022, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount on line 13, for each applicable column, plus 75 percent of the difference between line 14 minus line 13, plus the amount from line 9.01. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 through 4, the amount from line 13, plus the amount from line 9.01, for each applicable column. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 49.

For former MDHs, line 15 is calculated based on the amounts in column 1. For former MDHs (Worksheet S-2, Part I, line 37.01, is yes) for FY 2016, for cost reporting periods that begin on or after January 1, 2016, if line 14, column 1, is greater than line 13, column 1, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap January 1, 2016, and end on or before September 30, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap

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January 1, 2016, and October 1, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4.

For former MDHs for FY 2017, for cost reporting periods that begin October 1, 2016, enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap October 1, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap September 30, 2017, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4.

Line 16 (Corresponds to Worksheet E, Part A, line 50)--Enter in columns 2 through 4, the amounts computed from line 26, columns 2 through 4. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 50. If Worksheet S-2, Part I, line 47, column 2, is yes, and Worksheet S-2, Part I, line 48, column 2, is no, do not transfer the amount from Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, line 54)--Enter the add-on payment for new technologies. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 17.01 (Corresponds to Worksheet E, Part A, line 55)--Do not complete this line. Organ acquisition costs are not included in the low volume adjustment calculation.

Line 17.02 (Corresponds to Worksheet E, Part A, line 68)--For discharges on or after October 1, 2014, enter the credits for replaced devices. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 18 (Corresponds to Worksheet E, Part A, line 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 through 4 accordingly. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 (Subtotal)--Enter in columns 2 through 4, the sum of amounts on lines 15, 16, 17, and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 through 4, the sum of the amounts on lines 15, 16, 17, and 17.02.

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Line 20 (Corresponds to Worksheet L, Part I, line 1)--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1, column 1, and, if applicable, column 1.01.

Line 20.01 (Corresponds to Worksheet L, Part I, line 1.01)--Enter the Model 4 BPCI Capital DRG other than outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1.01, column 1, and, if applicable, column 1.01.

Line 21 (Corresponds to Worksheet L, Part I, line 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.

Line 21.01 (Corresponds to Worksheet L, Part I, line 2.01)--Enter the Model 4 BPCI Capital DRG outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.01.

Line 22 (Corresponds to Worksheet L, Part I, line 5)--Enter the ratio calculated from Worksheet L, Part I, line 5, in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, line 6)--Multiply line 22 by the sum of lines 20 and 20.01. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10, in all applicable columns.

Line 25 (Corresponds to Worksheet L, Part I, line 11)--Multiply line 24 by the sum of lines 20 and 20.01, and enter the result. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, line 12)--Enter the sum of lines 20, 20.01, 21, 21.01, 23, and 25. If the amounts on lines 20 and/or 20.01, columns 3 and/or 4, or applicable subscripts of either column, pertain to rural status, enter zero. Transfer this amount to line 16. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 12.

Low-volume payment adjustment--Effective for discharges occurring during FFYs 2011 and subsequent, compute the amount of the low-volume adjustment as follows:

Line 27--Low-volume adjustment factor--Enter the appropriate adjustment factor in columns 3 and 4. For FFYs 2011 through 2018, obtain the adjustment factor from the appropriate IPPS final rule. *For FFYs 2019 through 2022, calculate the adjustment factor in accordance with 42 CFR 412.101(c)(3), using the most recently submitted cost report.* For FFYs 2023 forward (discharges on or after October 1, 2022), use an adjustment factor of 25 percent.

Line 28 (Corresponds to Worksheet E, Part A, line 70.96 discharges prior to October 1)--Multiply line 19 by line 27. Transfer this amount to the cost report, Worksheet E, Part A, line 70.96.

Line 29 (Corresponds to Worksheet E, Part A, line 70.97 discharges on or after October 1)--Multiply line 19 by line 27. Transfer this amount to the cost report, Worksheet E, Part A, line 70.97.

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EXHIBIT 4
LOW-VOLUME ADJUSTMENT CALCULATION SCHEDULE

LOW-VOLUME CALCULATION		PROVIDER CCN:	PERIOD: FROM: _____ TO: _____				
EXHIBIT 4							
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)	Pre/Post Entitlement	Prior to 10/1 (3)	On and after 10/1 (4)	Total (cols. 2 through 4) (5)
1	DRG Amounts Other than Outlier Payments	1	(1)	(2)	(3)	(4)	(5)
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01					1
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02					1.01
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03					1.02
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04					1.03
2	Outlier payments for discharges (see instructions)	2					1.04
2.01	Outlier payment for discharges for Model 4 BPCI	2.02					2
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03					2.01
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04					2.02
3	Operating outlier reconciliation	2.01					2.03
4	Managed Care Simulated Payments	3					3
Indirect Medical Education Adjustment							
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21					4
6	IME payment adjustment (see instructions)	22					5
6.01	IME payment adjustment for managed care (see instructions)	22.01					6
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor (see instructions)	27					6.01
8	IME add-on adjustment amount (see instructions)	28					
8.01	IME payment adjustment add on for managed care (see instructions)	28.01					7
9	Total IME payment (sum of lines 6 and 8)	29					8
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01					8.01
Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage (see instructions)	33					9
11	Disproportionate share adjustment (see instructions)	34					9.01
11.01	Uncompensated care payments	36					10
Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment (see instructions)	46					11
13	Subtotal (see instructions)	47					12
14	Hospital specific payments (completed by SCH and MDH, small rural hospitals only) (see instructions)	48					13
15	Total payment for inpatient operating costs (see instructions)	49					14
16	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50					15
17	Special add-on payments for new technologies	54					16
17.01	Net organ acquisition cost	55					17
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68					17.01
18	Capital outlier reconciliation adjustment amount (see instructions)	93					17.02
19	SUBTOTAL		(Amt. from Wkst. L)				18
		Wkst. L, line	(1)	(2)	(3)	(4)	19
20	Capital DRG other than outlier	1					(5)
20.01	Model 4 BPCI Capital DRG other than outlier	1.01					20
21	Capital DRG outlier payments	2					20.01
21.01	Model 4 BPCI Capital DRG outlier payments	2.01					21
22	Indirect medical education percentage (see instructions)	5					21.01
23	Indirect medical education adjustment (see instructions)	6					22
24	Allowable disproportionate share percentage (see instructions)	10					23
25	Disproportionate share adjustment (see instructions)	11					24
26	Total prospective capital payments (see instructions)	12					25
		Wkst. E, Pt. A, line	(Amt. to Wkst. E, Pt. A)				26
		(0)	(1)	(2)	(3)	(4)	(5)
27	Low-volume adjustment factor						27
28	Low-volume adjustment (transfer amount to Wkst. E, Pt. A, line 70.96) (prior to 10/1)						28
29	Low-volume adjustment (transfer amount to Wkst. E, Pt. A, line 70.97) (on and after 10/1)						29

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Rev. 15

Instructions for Completing Exhibit 5--Adjustment to Hospital Payments for Hospital Acquired Conditions (HAC) Calculation Schedule:

Section 3008 of ACA 2010 establishes the HAC Reduction Program, beginning in FFY 2015 (discharges occurring on or after October 1, 2014), for IPPS hospitals to improve patient safety. HACs are medical errors or serious infections that patients contract while in the hospital. Under the HAC Reduction Program, a 1 percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specific fiscal year. For SCHs and MDHs, the HAC reduction percentage applies to either the federal payment rate or the HSP rate, whichever results in a greater operating IPPS payment. See 2015 IPPS final rule (79 FR 50087-50104 (August 22, 2014)).

Applicable IPPS hospitals subject to the HAC reduction adjustment for discharges occurring during FFY 2015 (i.e., discharges occurring on or after October 1, 2014, through September 30, 2015) are listed in Table 17 of the FY 2015 IPPS final rule. Consult the appropriate CMS final rule for the table listing IPPS hospitals subject to the HAC reduction adjustment. The HAC reduction adjustment amount is calculated after all IPPS per discharge payments, which includes adjustment for DSH (including the uncompensated care payment (UCP)), IME payments, outliers, new technology, net organ acquisition costs, credits for replace devices, readmissions, HVBP, and capital payments. The HAC reduction adjustment calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during cost report settlement if any of the payment amounts upon which the HAC reduction adjustment is based are also recalculated at cost report settlement (for example, payments for DSH, IME, Low volume adjustment, or federal rate versus HSP rate payments for SCHs and MDHs).

After the cost report is calculated for settlement, the HAC reduction adjustment must be calculated by FFY. If the cost report overlaps a FFY, the information computed on Worksheet E, Part A, must be recomputed by FFY accordingly. The amounts are not prorated (except where noted), but must be calculated using the appropriate information. The following payment amounts are required to calculate the HAC reduction adjustment by FFY:

- Operating Federal IPPS payments;
- Operating HSR payments;
- Operating Outlier payments including any Operating Outlier Reconciliation amounts;
- Operating IME payments;
- Operating IME payments for Medicare Advantage patients;
- Operating DSH payments;
- Uncompensated care payments;
- ESRD adjustment payments;
- Total capital IPPS payment;
- New technology payments;
- Credits for replaced devices;
- Low volume adjustment;
- HVBP payment adjustment;
- HRR adjustment; and
- Capital outlier reconciliation amounts (if applicable, see instructions)

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Complete Exhibit 5 to compute the HAC reduction adjustment applicable to this cost reporting period. **The following Exhibit 5 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated.**

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A, and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A, and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

Column 2--Enter amounts related to discharges occurring during the applicable provider's HAC reduction period prior to October 1. If the cost reporting period is not concurrent with a federal year (October 1, through September 30), do not include discharges occurring on or after October 1, in this column. If the provider's classification (i.e. SCH to small rural) changes during the HAC reduction period, use subscripted column 2.01 to accommodate the change for discharges occurring prior to October 1st.

Column 3--Enter amounts related to discharges occurring during the applicable provider's HAC reduction period on or after October 1. If the cost reporting period is concurrent with a federal year (October 1, through September 30), report all discharges occurring on or after October 1, in this column. If the provider's classification (i.e. SCH to small rural) changes during the HAC reduction period, use subscripted column 3.01 to accommodate the change for discharges occurring prior to October 1.

When a hospital with a cost reporting period that is not concurrent with a FFY is subject to the HAC reduction adjustment for only part of the cost reporting period, complete both columns 2 and 3. If Worksheet S-2, Part I, line 40, column 1, is "N" do not complete the HAC reduction program adjustment amount in column 2, line 32. If Worksheet S-2, Part I, line 40, column 2, is "N" do not complete the HAC reduction program adjustment amount in column 3, line 32.

Columns 2 and 3--Use the beginning and ending dates of the applicable portion of the cost reporting period as the respective column headings.

Column 4--Sum of columns 2 and 3. Column 4 must equal column 1 and any resulting rounding difference must be applied to the highest value in column 2 or column 3.

Line Descriptions

Line 1--Do not use this line.

Line 1.01 (Corresponds to Worksheet E, Part A, line 1.01)--Enter the DRG amounts other than outlier payments for discharges occurring prior to October 1, in column 2.

Line 1.02 (Corresponds to Worksheet E, Part A, line 1.02)--Enter the DRG amounts other than outlier payments for discharges occurring on or after October 1 in column 3.

Line 1.03 (Corresponds to Worksheet E, Part A, line 1.03)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. Effective for cost reporting periods that overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1, in column 2.

Line 1.04 (Corresponds to Worksheet E, Part A, line 1.04)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

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Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. *For cost reporting periods beginning on or after October 1, 2018, do not complete this line, but complete lines 2.02 and 2.03.*

Line 2.01 (Corresponds to Worksheet E, Part A, line 2.02)--Enter the outlier payment for discharges for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2.02 (Corresponds to Worksheet E, Part A, line 2.03)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring prior to October 1, in column 2.

Line 2.03 (Corresponds to Worksheet E, Part A, line 2.04)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring on or after October 1, in column 3.

Line 3 (Corresponds to Worksheet E, Part A, line 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92, for each respective period. The lump sum utility produces a claim-by-claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the contractor must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the FFYs spanned by the cost report separately. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, line 3)--Enter the IME for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care simulated payments from the PS&R. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 5 (Corresponds to Worksheet E, Part A, line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 and 3.

Line 6 (Corresponds to Worksheet E, Part A, line 22)--For cost reporting periods that overlap October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{(1 + \text{line 5}) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of lines 1.01, 1.02, 1.03, 1.04 and line 4}\}$. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 22.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{(1 + \text{line 5}) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of lines 1.01, 1.02, 1.03 and 1.04}\}$. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 22.

Line 6.01 (Corresponding to Worksheet E, Part A, line 22.01)--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times $\{(1 + \text{line 5}) \text{ to the } .405 \text{ power} - 1\}$ times line 4.

Line 7 (Corresponds to Worksheet E, Part A, line 27)--Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 and 3.

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Line 8 (Corresponds to Worksheet E, Part A, line 28)--IME Add On Adjustment--For cost reporting periods that overlap October 1, 2014, enter the sum of lines 1.01, 1.02, 1.03, 1.04, and 4, multiplied by the factor on line 7.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03, and 1.04, multiplied by the factor on line 7.

Line 8.01 (Corresponding to Worksheet E, Part A, line 28.01)--Total IME Add On Adjustment for Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 29.

Line 9.01 (Corresponding to Worksheet E, Part A, line 29.01)--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 6.01 and 8.01. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 29.01.

Line 10 (Corresponds to Worksheet E, Part A, line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 and 3.

Line 11 (Corresponds to Worksheet E, Part A, line 34)--Multiply (line 10 times the sum of lines 1.01, 1.02 1.03, and 1.04) times 25 percent. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 34.

Line 11.01 (Corresponds to Worksheet E, Part A, line 36)--Enter the uncompensated care payments. For cost reporting periods that overlap October 1, enter in column 2, the uncompensated care payments from Worksheet E, Part A, column 1, line 35.03, and enter in column 3, the uncompensated care payments from Worksheet E, Part A, column 2, line 35.03.

Line 12 (Corresponds to Worksheet E, Part A, line 46)--Prorate, in columns 2 and 3, the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, line 47)--Enter the sum of lines 1.01, 1.02, 2, 2.01, 2.02, 2.03, 3, 9, 11, 11.01, and 12. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 47.

Line 14 (Corresponds to Worksheet E, Part A, line 48)--For SCHs and MDHs, enter the applicable hospital-specific payments. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 48. If Worksheet E, Part A, line 47, is greater than Worksheet E, Part A, line 48, do not complete this line.

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Line 15 (Corresponds to Worksheet E, Part A, line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 and 3, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 and 3, the amount reported on line 14, plus the amount from line 9.01, for each applicable column. For MDH discharges occurring on or before October 1, 2022, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 and 3, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 and 3, the amount on line 13, for each column, plus 75 percent of the difference between line 14 minus line 13, plus the amount from line 9.01. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 and 3, the amount from line 13, plus the amount from line 9.01, for each column. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 49.

For former MDH's, line 15 is calculated based on the amounts in column 1. For former MDHs (Worksheet S-2, Part I, line 37.01 is yes) for FY 2016, for cost reporting periods that begin on or after January 1, 2016, if line 14, column 1 is greater than line 13, column 1, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap January 1, 2016, and end on or before September 30, 2016, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap January 1, 2016, and October 1, 2016, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3.

For former MDHs for FY 2017, for cost reporting periods that begin October 1, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap October 1, 2016, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap September 30, 2017, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3.

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Line 16 (Corresponds to Worksheet E, Part A, line 50)--Enter in columns 2 and 3, the amounts computed from line 26, columns 2 and 3. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 50. If Worksheet S-2, Part I, line 47, column 2, is yes, and Worksheet S-2, Part I, line 48, column 2 is no, do not transfer the amount from Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, line 54)--Enter the add-on payment for new technologies. The PS&R information must be split and reported in columns 2 and 3 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 17.01 (Corresponds to Worksheet E, Part A, line 55)--Do not complete this line. Organ acquisition costs are not included in the HAC reduction calculation.

Line 17.02 (Corresponds to Worksheet E, Part A, line 68)--Enter the credits for replaced devices. The PS&R information must be split and reported in columns 2 and 3 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 18 (Corresponds to Worksheet E, Part A, line 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 and 3. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 Subtotal--Enter in columns 2 and 3, the sum of amounts on lines 15, 16, 17, 17.02, and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 and 3, the sum of the amounts on lines 15, 16, 17, and 17.02.

Line 20 (Corresponds to Worksheet L, Part I, line 1)--Enter the amount of the federal rate portion of the capital DRG payments other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 1, column 1, and, if applicable, column 1.01.

Line 20.01 (Corresponds to Worksheet L, Part I, line 1.01)--Enter the Model 4 BPCI Capital DRG other than outlier payments. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 1.01, column 1, and, if applicable, column 1.01.

Line 21 (Corresponds to Worksheet L, Part I, line 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 2.

Line 21.01 (Corresponds to Worksheet L, Part I, line 2.01)--Enter the Model 4 BPCI Capital DRG outlier payments. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 2.01.

Line 22 (Corresponds to Worksheet L, Part I, line 5)--Enter the ratio calculated from Worksheet L, Part I, line 5, in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, line 6)--Multiply line 22 by the sum of lines 20 and 20.01. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10, in applicable columns.

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Line 25 (Corresponds to Worksheet L, Part I, line 11)--Multiply line 24 by the sum of lines 20 and 20.01, and enter the result. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, line 12)--Enter the sum of lines 20, 20.01, 21, 21.01, 23, and 25. If the amounts on lines 20 and/or 20.01, columns 2 and/or 3, or applicable subscripts of either column, pertain to rural status, enter zero. Transfer this amount to line 16 of this exhibit. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 12.

Line 27--Do not use. This line was left blank to maintain line number consistency between the low-volume and HAC adjustment worksheets.

Line 28 (Corresponds to Worksheet E, Part A, line 70.96 discharges prior to October 1)--Enter the amount from Worksheet E, Part A, line 70.96, in column 2.

Line 29 (Corresponds to Worksheet E, Part A, line 70.97 discharges on or after October 1)-- Enter the amount from Worksheet E, Part A, line 70.97, in column 3.

Line 30 (Corresponds to Worksheet E, Part A, line 70.93)--Enter the HVBP payment adjustment amount. The PS&R information for Worksheet E, Part A, line 70.93, must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.93.

Line 30.01 (Corresponds to Worksheet E, Part A, line 70.90)--Enter in columns 2 and 3, the HVBP payment adjustment amounts from Worksheet E, Part A, line 102, columns 1 and 2, respectively. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.90.

Line 31 (Corresponds to Worksheet E, Part A, line 70.94)--Enter the HRR adjustment amount. The PS&R information for Worksheet E, Part A, line 70.94, must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.94.

Line 31.01 (Corresponds to Worksheet E, Part A, line 70.91)--Enter in columns 2 and 3, the HRR adjustment amounts from Worksheet E, Part A, line 104, columns 1 and 2, respectively. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.91.

Line 32 (Corresponds to Worksheet E, Part A, line 70.99)--Enter the HAC reduction adjustment amount. If you responded "N" on Worksheet S-2, Part I, line 40, column 1, do not complete the HAC reduction adjustment in column 2. If you responded "N" on Worksheet S-2, Part I, line 40, column 2, do not complete the HAC reduction adjustment in column 3. Enter in column 2, the sum of lines 19, 28, 30, 30.01, 31, and 31.01, times 1 percent. For cost reporting periods that overlap October 1, 2014, enter zero in column 2. Enter in column 3, the sum of lines 19, 29, 30, 30.01, 31, and 31.01, times 1 percent. Enter in column 4, the sum of columns 2 and 3. Transfer the amount in column 4 to the cost report calculated settlement, Worksheet E, Part A, line 70.99.

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EXHIBIT 5
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION SCHEDULE

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		PROVIDER CCN:	PERIOD: FROM: _____ TO: _____			
		Wkst. E, Pt. A, line (0)	(Amt. from Wkst. E, Pt. A) (1)	Prior to 10/1 (2)	On or after 10/1 (3)	Total (cols. 2 and 3) (4)
1	DRG Amounts Other than Outlier Payments	1				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02				1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03				1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04				1.04
2	Outlier payments for discharges (see instructions)	2				2
2.01	Outlier payment for discharges for Model 4 BPCI	2.02				2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03				2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04				2.03
3	Operating outlier reconciliation	2.01				3
4	Managed Care Simulated Payments	3				4
Indirect Medical Education Adjustment						
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21				5
6	IME payment adjustment (see instructions)	22				6
6.01	IME payment adjustment for managed care (see instructions)	22.01				6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payments adjustment factor (see instructions)	27				7
8	IME add-on adjustment amount (see instructions)	28				8
8.01	IME payment adjustment add-on for managed care (see instructions)	28.01				8.01
9	Total IME payment (sum of lines 6 and 8)	29				9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01				9.01
Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage (see instructions)	33				10
11	Disproportionate share adjustment (see instructions)	34				11
11.01	Uncompensated care payments	36				11.01
Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment (see instructions)	46				12
13	Subtotal (see instructions)	47				13
14	Hospital specific payments (completed by SCH and MDH, small rural hospitals only) (see instructions)	48				14
15	Total payment for inpatient operating costs (see instructions)	49				15
16	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50				16
17	Special add-on payments for new technologies	54				17
17.01	Net organ acquisition cost	55				17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68				17.02
18	Capital outlier reconciliation adjustment amount (see instructions)	93				18
19	SUBTOTAL		(Amt. from Wkst. L) (1)	(2)	(3)	(4)
20	Capital DRG other than outlier	1				20
20.01	Model 4 BPCI Capital DRG other than outlier	1.01				20.01
21	Capital DRG outlier payments	2				21
21.01	Model 4 BPCI Capital DRG outlier payments	2.01				21.01
22	Indirect medical education percentage (see instructions)	5				22
23	Indirect medical education adjustment (see instructions)	6				23
24	Allowable disproportionate share percentage (see instructions)	10				24
25	Disproportionate share adjustment (see instructions)	11				25
26	Total prospective capital payments (see instructions)	12				26
		Wkst. E, Pt. A, line (0)	(Amt. from Wkst. E, Pt. A) (1)	(2)	(3)	(4)
27	Low-volume adjustment prior to October 1	70.96				27
28	Low-volume adjustment on or after October 1	70.97				28
29	HVBP payment adjustment (see instructions)	70.93				29
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90				30
31	HRG adjustment (see instructions)	70.94				31
31.01	HRG adjustment for HSP bonus payment (see instructions)	70.91				31.01
32	HAC Reduction Program adjustment (see instructions) (amount in col. 4 to Wkst. E, Pt. A)	70.99				32

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